Department of Community and Human Services
Mental Health, Chemical Abuse and Dependency Services Division

10-Year Plan to End Homelessness In King County

"Begin at Home – Simons Senior Apartments" A Housing First Pilot Project for Older Adults

One Year Outcomes

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EXECUTIVE SUMMARY

Individuals who are homeless for long periods of time and disabled by mental illnesses, substance use disorders or medical illnesses often cycle between homelessness, hospitals, and jails. To address these needs the City of Seattle, King County, United Way of King County and the Seattle and King County Housing Authorities have provided resources for a number of "Housing First" projects characterized by low-barrier access to housing and integrated psychiatric, chemical dependency, and health care services that are voluntary, intensive and easily accessible. There are no "readiness" or abstinence criteria for individuals to obtain or keep housing, and housing is permanent rather than transitional.

The purpose of this report is to present one-year outcomes for one of these Housing First projects - Begin At Home (BAH) – Langdon and Anne Simons Senior Apartments. Data include client characteristics and vignettes, participant feedback, process evaluation findings, and outcomes including jail and acute care service utilization.

BAH-Simons Apartments are operated by Plymouth Housing Group in a 95-unit building, newly-constructed in 2008 in the Belltown area of Seattle. Services for BAH-Simons integrate mental health, chemical dependency and primary health care into a single, comprehensive on-site team that address an array of health conditions as well as complex behavioral issues. Help with applying for and obtaining income and food assistance benefits and development of self-sufficiency are also provided.

PARTICIPANTS

Plymouth designated 45 units of the Simons building for the BAH-Simons Housing First program. The program focuses on providing housing and support for older adults in the downtown Seattle area who are frequent users of the Dutch Shisler Sobering Center, local jails, hospital or emergency services, homeless emergency services such as shelters, or Veterans Administration acute care services. Individuals who have served in the U.S. military are prioritized. Participants are to meet the federal definition of chronic homelessness, including having a disabling medical or psychiatric condition. The first tenant moved into housing in January, 2008 and the program was at capacity by the end of May, 2008.

The initial 45 participants were:

- predominantly male (n=36; 80%)
- older adults (average age of 60.3 yrs; range 55 to 72 years old)
- 50% Caucasian 38% African-American, 12% American Indian,
- chronically homeless with length of homelessness ranging from four months to 42 years
- predominantly individuals who had served in the U.S. military (64%).

PROCESS EVALUATION HIGHLIGHTS

One of the process goals of BAH-Simons is to connect participants who have been high utilizers of acute care services with primary care services. Indeed, **within one year, 40 of the 45 BAH-Simons participants (89%) had contact with primary care** via the nurse on the BAH-Simons team. Within a year, 89% were also receiving some type of steady income support (e.g., Social Security, Veteran's Administration benefits) and 73% had health insurance.

BAH-Simons participants also completed surveys about the program at six- and 12- months following admission. Participants reported a wide range of positive aspects of the program. Most frequently, participants valued having their own place and the general care and help that they were provided. At the six-month survey, participants noted a **wide range of program impacts, from improvement in housing, to not using drugs, to having more control over life and improvement in dealing with crises and daily problems**. At 12 months, participants also noted improvement in work and/or school. The only negative theme among the areas reported for improvement was that participants would like the rules relaxed regarding guests.

OUTCOME EVALUATION HIGHLIGHTS

BAH-Simons participants showed notable positive outcomes after 12 months in the program, particularly in housing retention and reduction in use of acute healthcare services. Specifically:

- ✓ Nearly all participants (93%) retained their housing in the BAH-Simons program for one year
- ✓ Harborview inpatient admissions for participants fell 76% and hospital days fell by 81%
- ✓ Harborview Emergency Department contacts fell by 59%
- ✓ VA inpatient admissions for participants fell 65% and hospital days fell by 84%
- ✓ VA Emergency Department contacts fell by 59%
- ✓ Inpatient psychiatric hospitalizations rose slightly from two admissions (two people) to four admissions (one person)
- ✓ King County jail bookings showed no significant change, with 17 bookings for the BAH-Simons participants as a whole during the year prior to their admission and 16 during the subsequent year
- ✓ Sobering Center contacts fell markedly from 1,440 during the year prior to program entry to 25 during the subsequent year (98% reduction)
- ✓ For the first year of the program, total costs of $480,580 (average of $10,680 per person) were offset by reductions in acute care and shelter utilization of at least $714,379 (average of $15,875 per person), representing a savings of $233,799 (average of $5196 per person).

RECOMMENDATIONS

The positive findings from the BAH-Simons project -- particularly the remarkable reductions in use of high-cost acute care services -- suggest that a Housing First approach may be particularly worthwhile to stabilize individuals selected on the basis of intensive service needs and/or high service utilization.

The evaluation data do, however, suggest some points for potential program improvement. For example, per some negative comments by participants, the program may want to examine program rules regarding guests. Also, the number of people using drugs or alcohol, rose from 23 to 30 after one year, suggesting the need for increased attention to chemical dependency issues and continuation of on-site chemical dependency counseling and referral. However, substance use data was not collected in a consistent and reliable manner, which could also have affected these results. Finally, while rates of inpatient psychiatric hospitalization and jail incarceration were relatively low, further investigation of each case in which these sentinel events occurred could be fruitful for a program improvement process.

Thus, the evaluation suggests:

- Continue successful efforts to house this population and reduce acute healthcare utilization
- Increase attention to chemical dependency issues and continue on-site counseling and referral
- Increase consistency and reliability of substance use ratings
- Further examine cases in which psychiatric hospitalization or incarceration occurred

Our findings suggest that these processes, coupled with selection of individuals most in need of housing plus intensive services, can lead to continued positive outcomes for BAH-Simons.

BACKGROUND

P. is a 63 year-old veteran who had served for four years and had an honorable discharge. He became homeless a few years after discharge and has been homeless for the last 37 years. Daily alcohol use contributed to his continued homelessness.

Shortly after he moved into BAH-Simons, he was found to be sleeping on the floor. He reported having trauma-related nightmares that made him fearful of falling out of his bed. Several months later, a Housing Case Manager stopped by his apartment and it was clear that he had become more comfortable living there. He was found cooking a small pot of macaroni and cheese, his red sleeping bag neatly unrolled on his bed. He had secured a couch, a rug, a coffee table, and an old radio. He said he felt "like a little boy in a giant warehouse." However, he also remarked, "But I can do this, don't worry, I can do this". At the time of this writing, he has been housed in the program nearly two years.

P. is one of the many faces of homeless individuals in our community and his story gives us hope about what can be accomplished with successful supported housing programs. According to the 2008 One Night Count, over 8,439 individuals are homeless each night in King County. Estimates suggest that about 8% of homeless individuals in shelters have served in the U.S. military. National statistics indicate that approximately three times as many people experience homelessness in the course of a year as are counted in a point-in-time count. Applied to King County, this ratio would mean that at least 24,000 people experience homelessness annually. The One Night Count indicates that roughly 20% of these individuals are chronically homeless - that is, they are disabled, often by mental illnesses and chemical dependency, and they have experienced long or repeated episodes of homelessness.

Individuals who are homeless for long periods of time often cycle between homelessness, hospitals, jails, and other institutional settings. In Seattle and throughout King County, public and private funders have made a significant commitment to fund housing with supportive services designed to meet the needs of people who are chronically homeless. The City of Seattle, King County, United Way of King County and both the Seattle and King County Housing Authorities have provided resources for a number of "Housing First" projects characterized by low-barrier access to housing and integrated psychiatric, chemical dependency, and health care services that are voluntary, intensive and easily accessible. These entities have recently embarked on a joint goal of producing 1,000 such units by 2015.

PURPOSE OF THIS REPORT

This report is the third to document outcomes for a local Housing First project. The first detailed the remarkable positive outcomes for individuals in the Begin-at-Home – Plymouth on Stewart project focused on a downtown population of homeless individuals who were frequent and high-cost users of Harborview hospital and emergency services. The second report described outcomes for the South King County (SKC) Housing First project, a scattered-site model which focuses on chronically homeless individuals in the south King County area.

The current report provides analysis of the Begin-at-Home (BAH) – Simons project which focuses efforts on older adults in downtown Seattle who are frequent users of the Dutch Shisler Sobering Center, local jails, hospital or emergency services, or Veterans Administration acute care services. The report includes data regarding BAH-Simons client characteristics and vignettes, participant feedback, process evaluation findings, and outcomes, including jail and acute healthcare service utilization.

PILOT PROGRAM DESCRIPTION

BAH-Simons as well as BAH-Stewart and the SKC Housing First program employ a Housing First approach.

The "Housing First" Model

The housing first model represents a paradigm shift that offers low-barrier access to housing and clinical services. The following characterize low barrier housing and services:

- ✓ Services that are voluntary, intensive and easily accessible on site
- ✓ No "readiness" or sobriety criteria to obtain housing -- individuals are housed directly from street
- ✓ Housing is permanent and considered to be the person's home, not residential treatment
- ✓ Housing units are held for the person up to a 90-day absence
- ✓ Tenants hold leases and have full rights and obligations of tenancy
- ✓ Eviction viewed as a last resort.

The BAH-Simons program and other Housing First programs emphasize participants being respectful to neighbors and within the building community, and they utilize interventions that target behaviors negatively impacting ability to remain in the community (e.g., managing day-to-day responsibilities of being in an apartment and conflicts with other tenants). Services focus on harm reduction, relapse prevention and recovery associated with mental illness, substance use disorders, and medical conditions.

BAH - Simons

Overview

Plymouth Housing Group (PHG) developed and manages the BAH-Simons project. PHG provides permanent supportive housing and services for single adults who are homeless across King County. Located at 3rd and Blanchard in the Belltown area of downtown Seattle, the Langdon and Anne Simons Senior Apartments is a newly-constructed building completed in 2008. Simons Apartments is a 95 unit building designed to house three staff and 92 homeless individuals 55 years old and older living at or below 30% of Area Median Income (AMI). Plymouth designated 45 units for people with long-term homelessness histories who are high utilizers of costly public services (medical, mental health and chemical dependency services) and shelters. These 45 units are the subject of this evaluation. With an aim to support homeless individuals who had served in the U.S. Military, twenty-three (23) of these units are set aside for veterans meeting the above criteria, ten of which are designated for the Veterans Administration clients and 10 for King County Veteran Resources clients. Of the 92 clients units in the building, 47 house veterans.

The first BAH-Simons tenant moved into housing in January, 2008 and the program was at capacity by the end of May, 2008. Pre-housing engagement, intensive outreach efforts, and creative rapport building was used to house individuals as quickly as possible while meeting the paperwork requirements of the tax credit and housing authority entities. Many tenants would not have been able to complete the application packets without the assistance of housing case managers.

Services for BAH-Simons integrate mental health, chemical dependency and primary health care into a single, comprehensive on-site team. The multidisciplinary team with 24/7 coverage provides pre-move engagement, on-site stabilization and eviction prevention, help with obtaining income and food assistance benefits, counseling and referral, and development of self-sufficiency skills. Housing case managers have a 23:1 client-to-staff ratio and many services are provided at the person's residence.

The BAH-Simons team is committed to fostering the positive community integration, socialization and wellness of participants. They arrange an average of 25 community events monthly, including meal events, sobriety groups, art groups, educational speakers, and the like. The program also takes advantage of opportunities for training staff in community resources and evidence-based practices.

A representative list of training and activities includes:

- inviting speakers to teach tenants about hygiene, dental care, street safety, and living wills
- conducting ongoing Life Skills coaching
- contracting with the American Red Cross for interpretation service
- initiating a payment plan for move-in funds to allow for rapid leasing
- providing Certificates of Appreciation for tenants who pass monthly unit inspections or are engaged in the community in volunteer roles
- briefing staff about Pike Market Senior Center /food bank and services and sharing information with tenants
- participating in the Plymouth Housing Group picnic and holiday events
- coordinating joint VA and King County Vets Program meetings
- hosting tenant activities on regular basis such as shopping, open grill nights, community potlucks, and a gardening group to maintain the three outdoor courtyards
- creation of a monthly community meeting for tenants to voice concerns, ideas, and opinions about the building in which they live
- obtaining staff training regarding serving veterans, Motivational Interviewing, grief and loss

One staff person says, "Begin at Home folks have stated to me that they truly enjoy the privacy of their own apartment, yet having their own apartment, they say, has also has brought on a new loneliness. I know that loneliness is a trigger for all sorts of things for all kinds of people. Loneliness can trigger depression, alcohol and drug relapse and suicidal ideation, all of which may have a negative effect on housing stability. So, as a Housing Case Manager, I want to work to create opportunities for tenants to develop meaningful connection to their neighbors and their community. Engagement is the challenge!"

The Simons building also has 24/7 staffing at the 'front door', as do many other supported housing programs run by Plymouth. This staffing is provided by one Building Manager, one Building Coordinator and four Building Specialists. Together they maintain the safety and security of the building and tenants, enforce building rules, perform janitorial, and maintenance tasks, and respond to and report tenant and building emergencies in addition to managing the property as a rental property. To provide the necessary security, the staff:

- Monitor all areas of the building and systems with the use of security cameras and tapes.
- Monitor the building to ensure only authorized persons enter the building and all guests follow building rules and policies.
- Ensure the removal of unauthorized persons within PHG guidelines.
- Ban guests violating building rules when appropriate
- Decide which guests can or cannot enter the building based on building security and bans
- Log tenant guests in and out of the building and maintain log sheets
- Check and confirm validity of guest ID.

Funding and Staffing

BAH-Simons uses braided service dollars to allow for integrated mental health, chemical dependency and health care services. All services are available to all 92 client units (3 units are reserved for staff), although this report is evaluating participants in only 45 units. Specifically, service and operating funding from the following entities are provided for the 92 units:

$557,520 - Seattle Housing Authority (Section 8 vouchers) ($695 subsidy minus average $190 tenant portion X 12 months X 92 units)
$330,000 - City of Seattle Human Services:
4.0 FTE Housing Case Managers,
.50 FTE Program Manager,
.30 FTE Supervisor,
.80 FTE Registered Nurse
$95,000 - United Way of King County - client assistance funds (e.g., move-in supplies, translation services, activity funds, admin. supplies)
$982,520 annually for all 92 units – approximately $480,580 (45/92) for participants under study, a cost of $10,680; less than $11,000 per person per year of supported housing and services.

As noted above, the building also has six additional personnel who staff the 'front door' and provide an array of other building management functions. Providing front door security could arguably be considered part of this supported housing program and as such its costs could be included. Front door staff costs are calculated at a pay rate of $11/hour X 168 hours/week (i.e., 24 X 7 hours) X 52 weeks for a total of $96,096. If included in per client costs, this staffing would add $1,045 per client or $47,025 total.

Eligibility

BAH-Simons focuses on providing housing and support for older adults in the downtown Seattle area who are "high utilizers" of public services and shelters such as the Dutch Shisler Sobering Center, local jails, hospital or emergency services, homeless shelters, or Veterans Administration acute care services.

Specific participant eligibility criteria for BAH-Simons are:

1. =/> 55 years old

2. Income = or < 30% of Area Median Income

3. Meet Housing and Urban Development (HUD) definition of "chronic" homelessness including long-term homelessness (12 consecutive months or four episodes in prior three years) and at least one disabling physical or psychiatric condition that significantly impairs functional abilities

4. Referred by City of Seattle and PHG-approved entities* which have capacity to identify and refer individuals meeting eligibility criteria. The targeted individuals may include those who have a history of the circumstances below, or other circumstances that are considered high utilization:

   A. In the past three years, a pattern of <u>at least one</u> of the following:
   - Recurring involvement with police, corrections, or courts or jail (2+ arrests in one year)
   - Recurring visits to the Dutch Shisler Sobering Center (60+ in one year) or Detox facilities (2+ in one year)
   - Frequent hospital inpatient admissions and/or emergency room visits (5+ in one year)
   - Recurring, ongoing stays in emergency shelters (minimum 3 years of shelter use of 200+ days per year)

   B. High utilization of Veterans Administration services, as defined by VA

   * At program start-up approved entities included: AHA, DESC, Reach, YWCA, RCKC, Medical Respite, Compass Center, Salvation Army, Harborview, King County Veteran's Program, and all High Utilizers Group participants.

R. struggles with issues related to severe childhood abuse, and PTSD with depression. He has no steady income support. Initially, he did not want to apply for benefits because he had too much anxiety around the mandatory mental health evaluation associated with obtaining GAU. However, he is now becoming more open to completing the GAU process, knowing his Housing Case Manager is willing to be by his side during the evaluation. When his anxiety increases he also increases his alcohol intake. During periods of intoxication he has also become verbally assaultive and combative. R has been extremely intoxicated each time there has been an incident. He always apologizes to everyone in the morning. At times he proactively goes to speak with the BAH-Simons staff about his drinking. Staff have listened to his issues and have amended guests rules to incentivize positive behavior. R repeatedly states he will do anything to keep his housing. He does not want to be homeless again.

As can be seen in the table below, the tenants that moved in to the 45 units were from referral sources consistent with the eligibility criteria.

Table 1. Referral sources – Based On 'Lease-up Criteria'

Referral source	N
Veterans Administration	10
King County Veterans' program	9
Long-term shelter users	8
Long-term shelter users – Veterans	4
Hi-utilizer – REACH	9
Hi-utilizer - Respite	2
Hi-utilizer – Recovery Centers of King County	3
Total	45

EVALUATION DESIGN

King County provided in-kind .10 FTE to evaluate three housing programs begun under these initiatives.

The program evaluation involved both process and outcome evaluation components. The process evaluation included:

- a description of program participant characteristics including demographics, history of homelessness, disabling conditions
- case vignettes
- narratives regarding how staff worked to prevent eviction

Program elements examined as part of the process evaluation included:

- contacts with an on-site nurse following admission
- completion of benefit applications
- attainment of health insurance including Medicaid or Medicare
- participant-reported program satisfaction (six months and 12 months following admission)

The outcome evaluation used a pre-post comparison-group design. That is, measures for the year prior to program participation were compared with measures taken during the year following program admission for BAH-Simon participants. The outcome evaluation included analysis of change in:

- admissions and days in Harborview Medical Center inpatient units
- contacts with Harborview Medical Center Emergency Department
- admissions and days in inpatient psychiatric hospitals
- King County jail bookings and jail days
- admissions to the Dutch Shisler Sobering Support Center (DSSSC)
- Puget Sound Veterans Administration (VA) emergency and inpatient admissions and days

Analysis of change from admission to one year after admission was also conducted for:

- income support - movement to stable income sources and increased amount
- substance use
- engagement in services

The outcome evaluation also included descriptions of:

- participant disposition at exit from program
- participant self-reported program impact (via survey)

Electronic records from the King County MHCADSD information system, Harborview Medical Center, King County jail system, and the VA were used for the evaluation.

PROCESS EVALUATION

Participant demographic characteristics

The 45 participants were predominantly male (n=36; 80%) and had an average age of 60.3 yrs (SD=4.5) with range 55 to 72 years old. Race was reported for 42 participants. The breakdown was five (12%) Native American, 16 (38%) African-American, and 21 (50%) Caucasian.

Income sources at the time participants entered into housing are shown in the table below.

Table 2. BAH participant income sources

Income Sources	Number of participants*	Monthly payment
SSI/SSA/SSI	25	Average-$770
VA	9	Average -$751
GAU/GAX	6	All $339
Other	2	1@$400; 1@$1000
None	5	0
Total	45	Average =$654.6 (SD=$369.1)

*2 people had 2 categories of income so the column adds to 47 even though there were 45 participants

Twenty-eight people had food stamps with the average benefit amount being $103/month. Thirty-one of the 45 participants (69%) had some type of health insurance coverage (i.e., Medicaid, Medicare, VA, combination) at the time of admission.

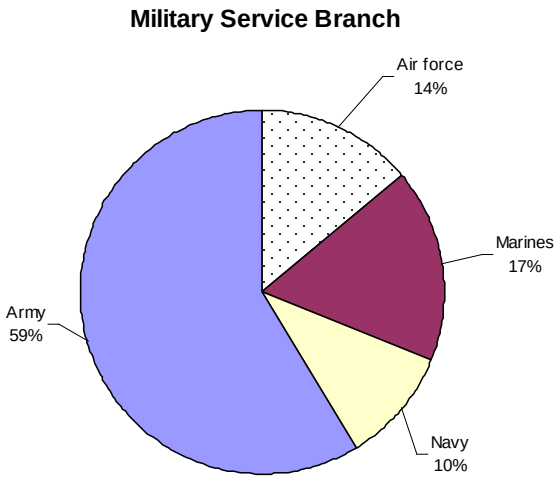
Homelessness History

All but three participants met the federal definition of chronic homelessness. All but five had been homeless continuously for the previous 365 days. Length of homelessness was four months to 42 years.

Veteran's Status

Twenty-nine participants (64%) reported to have served in the U.S. military at some point. Nine of these individuals were receiving some type of Veterans Administration financial support at the time of admission. Service dates ranged from 1953 to 1980. The branch of military service in which participants served is shown below. Twenty-three (79%) of those who had served, had an honorable discharge, and four others had a 'general' discharge.

Figure 1.



Conditions at Entry into Housing

BAH participants showed a wide range of disabling conditions. The HUD definition of disabling condition, within the definition of chronic homelessness, includes the Census definitions (i.e., uses assistive device for mobility, difficulty with functional activities and/or activities of daily living; or learning, developmental, or mental disability) or self-reported mental disability or alcohol or drug dependence. Data were available for all 45 participants and their conditions at entry are shown below. Many had multiple medical problems, so the condition list adds up to more than 45.

Table 3. BAH participant disabling and medical conditions at program entry

Conditions at Entry	Number of participants (N= 45)	% (of 45)
Federal (HUD) disabling conditions		
-mobility/ADL/functional/physical, sensory	21	47%
-mental illness	17	38%
-alcohol/drug	13	29%
-both mental illness and alcohol/drug	4	9%
-developmental	3	7%
Medical conditions		
-dental problems/infections	26	58%
-high blood pressure	18	40%
-hepatitis	12	27%
-shortness of breath	12	27%
-diabetes	10	22%
-broken bones	5	11%
-seizures	5	11%
-stomach/intestine infection/bleeding	4	9%
-cancer	3	7%
-chronic infection - including abscesses	2	4%
-heart disease/heart murmur	1	2%
-tuberculosis	1	2%
-frostbite	1	2%
-HIVAIDS	0	0%
Other conditions		
-domestic violence	2	4%

BAH-Simons participants had an average of 1.6 HUD defined disabling conditions (SD=1.0) and an average of 2.2 medical conditions of (SD=1.9).

Contact with On-site Nurse Following Admission

One of the process goals was to connect the medically-vulnerable BAH-Simons participants with health care services. We found that indeed 40 of the 45 BAH-Simons participants **(89%) had contact with the on-site nurse** within the year following their admission.

Completion of Benefit Application

Thirty-three of the 45 BAH-Simons participants had either Veterans Administration (VA) or Department of Social and Health Services (DSHS) benefits at the time of admission to the program. Seven of the remaining 12 participants (58%) completed a VA or DSHS application for benefits within one year of admission. As such, 41 of the 45 participants **(91%) had benefits within one year of admission**.

Attainment of Health Insurance

Thirty-one BAH-Simons participants had some type of health insurance at the time of admission to the program. Two of the remaining 14 (14%) tenants obtained health insurance within a year of admission. As such, 33 of the 45 participants **(73%) had health insurance within one year of admission**.

Eviction Prevention - Narratives

As part of the process evaluation, we asked staff to provide narratives about the ways in which they work with individuals to prevent eviction.

Staff go to great lengths to prevent eviction because it is a 'stain' on someone's housing record that makes it difficult to find housing in the future. For example, previously homeless participants often do not keep their apartments sanitary, which places them at risk for eviction. If helping the participant to keep the apartment clean does not work, the program assists the participant to secure chore services to help. Similarly, the program works with tenants to ensure that rent is paid, arranging for payeeship when necessary. When all else fails, staff negotiate an exit with a participant so as to avoid eviction. This occurred with two BAH-Simons residents who were acting violently. Below are two examples of how staff work with participants to prevent eviction.

D. was referred by the Veterans Administration. At his lease signing appointment, he became overwhelmed with the paperwork and nearly gave up, but with the Housing Case Manager's help he was able to complete it.

Soon after D. arrived he began reporting unverifiable break-ins and that he was being monitored by the government and followed by police. Although staff tried to validate his concerns, he later began believing that staff were involved in allowing people to enter his unit. He set fire crackers off in the building and his behavior became a serious issue when he threatened to harm staff and talked about having a weapon.

A "care conference" was held with D., his VA Social Worker, and building staff. This resulted in D. reconnecting with his psychiatrist at the VA. As a result of this linkage, D. started taking medications and attending community activities and his concerns about people breaking into his unit decreased. He became more focused on addressing his health concerns with the on-site nurse. He now also smiles and jokes with others

Even after **A.** moved into BAH-Simons, he returned to the shelter many times because he didn't fully understand that he had permanent housing. A. approached his Housing Case Manager with concerns that he was not receiving his full amount of Social Security money. After helping him navigate the Social Security Administration and his bank, it became clear that he was receiving the proper amount of funds, but was drinking most of it away. Additionally, he wasn't cleaning up after himself and he began failing inspections and falling behind in rent. Overtime, it became evident that A. had memory impairment and episodes of incontinence likely due to long term alcohol dependency.

With A. and other tenants, Housing Case Managers work on money management, including assistance to acquire rental vouchers or payees. They also problem-solve with tenants about how to manage money so as to ensure they are able to pay rent. With assistance from his Housing Case Manager, A. reconnected with his family and he ultimately allowed one family member to manage his money. His rent payments began arriving on time and money was set aside to pay for a chore worker. His Housing Case Manager linked him to the on-site nurse who had a physician come on-site to meet A. This was the first physician A had seen in at least ten years.

Participant -reported program satisfaction

Participants were surveyed six and 12 months following admission into the program. Questions included how often the person was seen by staff, perceived program benefits (results are shown in outcome evaluation section) and their views on the strengths and weaknesses of the program. Of the 45 participants, 42 completed the six-month surveys (two exited too soon and one was not surveyed until closer to the 12-month point). Most participants (n=41) also completed the 12-month survey (three exited too soon, one refused).

Participants reported a range in frequency of having contact with staff with most participants reporting being seen between once per month to one to two times per week.

Table 4. BAH participants staff contact

How often do you have contact with Housing First staff person?	6-month survey		12-month survey	
	N	% of 42	N	% of 41
Never	2	5%	3	7%
Once/month	12	29%	15	37%
Once/2 weeks	11	26%	5	12%
1-2 times/week	10	24%	15	37%
3-5 times/week	6	14%	3	7%
6+ times/week	1	2%	0	0%

At the six-month survey, all participants reported that this contact had been "very" or "somewhat" helpful. At the 12-month survey, three had changed their opinion and reported that it was not helpful and three were "not sure".

Program Strengths

Participants reported a wide range of positive aspects of the program. The table below shows topics mentioned by at least two people. Most participants provided a response, and of those who did, they most frequently reported that they valued having their own place and the general care and help that they were provided.

Table 5. Participant-reported program strengths

Participant-reported program strengths	6 –month survey		12-month survey	
	N	% of 32	N	% of 35
Care; offering help	9	28%	4	11%
Own place – off streets	8	25%	13	37%
Social opportunities; activities	4	13%	0	0%
Someone to talk to	3	9%	2	6%
Help with shopping, personal affairs	2	6%	0	0%
Safety/security	1	3%	5	14%
Independence	2	6%	4	11%
Financial assistance/incentives/$ for supplies	2	6%	5	14%
Clean place	0	0%	2	6%
Opportunities; chance to start over	2	6%	0	0%
Everything; overall benefit	0	0%	2	6%

Below are quotes from participants that exemplify their feelings toward the program:

"It's an adventure to have my own apartment; community services; games, computer, lunches from the church, gardening - I LOVE MY TUB!"

"[I can] relax whenever I want to- If I would have had a start like this (Simons) 35 years ago, maybe I wouldn't have lost it all"

"Plan my own sleep schedule, study pattern, cooking my own meals; everything- improved my living situation 100%. Not only do I have a much better feeling of independence, but relating with and practicing more compassion with others in this building"

About half of the participants at both time points reported program weaknesses or areas for improvement. The table below shows topics mentioned by at least two people. A notable theme is that participants would like the rules relaxed regarding guests.

Table 6. Participant-Reported Areas for Improvement

Participant-reported areas for improvement	6 –month survey		12-month survey	
	N	% of 12	N	% of 19
Relax rules – especially regarding guests	5	42%	8	42%
Show more respect; treat like adults	0	0%	2	11%
Address health issues; pain	0	0%	2	11%
More contact	1	8%	2	11%
More help	0	0%	2	11%

The participant survey, completed at six- and 12- months after program admission, included an item specifically about program rules. The question read "How do you feel about the program rules (regarding guests, room checks, and incentives)?" Their responses, presented in the table below, show that most people felt that the program rules were at least somewhat helpful. That said, it may be an area for the program to examine more closely.

Table 7. Participant Views Regarding Program Rules

	6-month survey	12-month survey
	N=40	N=40
Helped me a lot in settling into housing	16 (36%)	17 (38%)
Helped me a little in settling into housing	14 (31%)	8 (18%)
Didn't really help me, but I think it helped others get settled	8 (18%)	8 (18%)
Didn't really help anyone	2 (4%)	7 (16%)

OUTCOME EVALUATION

Participant Disposition at Exit from Program

Nearly all participants (93%) were retained in the BAH-Simons program for one year. This rate exceeds the 84% one-year retention rate for "continuous stayers" plus "intermittent stayers" found for Housing First program nationwide (HUD, 2007). Three individuals left the program after being determined to be a danger to residents or staff either by threatening statements and actions or dealing drugs in the building. Two of these had a 'negotiated' exit, while the third was terminated by the program. Staff worked over a long period of time to try to postpone and avert these decisions, meeting with the participants, their service providers, and negotiating changes in behavior. In two of the cases, a 'negotiated' exit was reached. In one case a court order for treatment ("least restrictive alternative order") was also obtained. Ultimately the decision was made that this individual was too much of a danger to other residents to be retained.

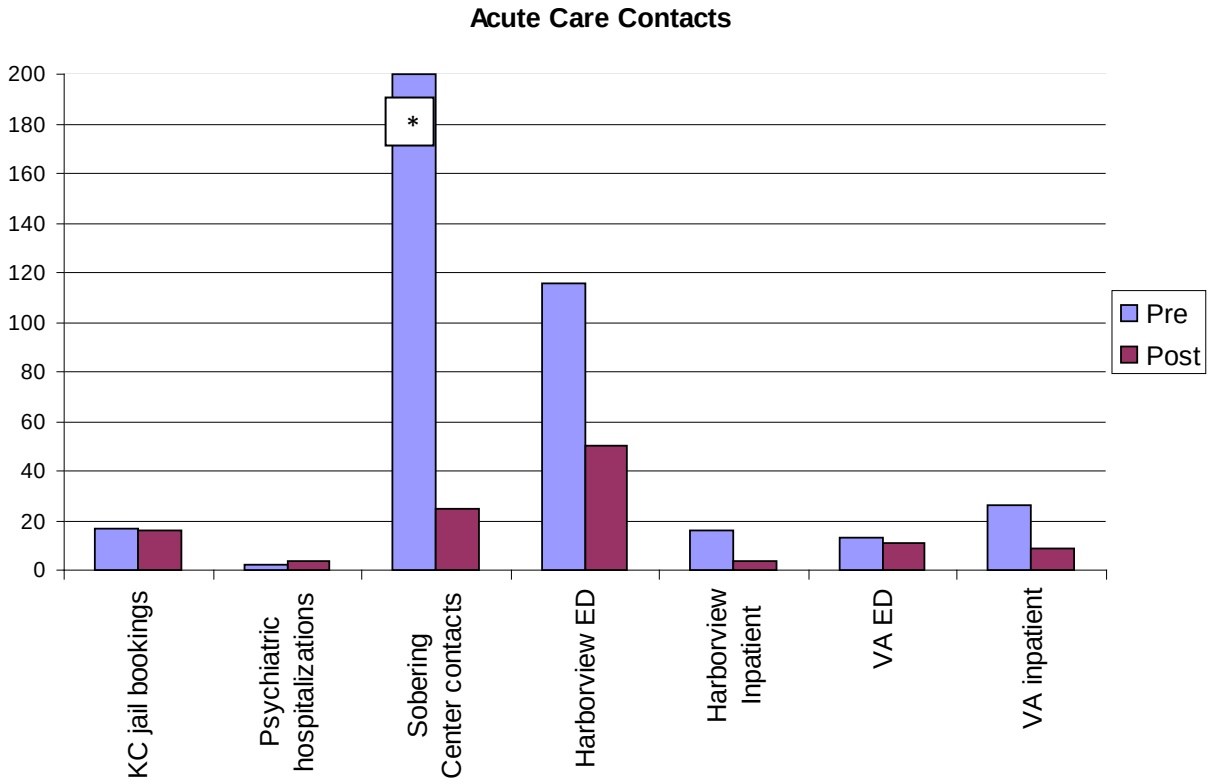
Harborview Medical Center

Ten people in BAH-Simons accounted for 16 Harborview inpatient admissions during the year prior to program admission (102 days), dropping to four people having four admissions during the following year (25 days). This represents a **60% reduction in the number of inpatient stays and a 75% reduction in days**. **Total inpatient charges dropped from $265,396 to $63,581.**

Twenty-nine BAH-Simons participants had 116 contacts with the Harborview Emergency Department during the year prior to program admission, dropping to 50 contacts among 23 participants during the following year. This represents a **57% reduction in Emergency Department contacts**. **Total Emergency Department charges dropped from $272,973 to $110,515.**

Harborview and other acute care contacts during the pre-program and post-program year are shown in figure 2 below.

Figure 2.



*Data point is beyond top of chart – "pre" Sobering Center contacts =1,440

Veterans Administration (VA) of Puget Sound

Twelve people in BAH-Simons accounted for 26 VA inpatient admissions during the year prior to program admission (274 days), dropping to five people having nine admissions during the following year (44 days). This represents a **65% reduction in the number of inpatient stays and an 84% reduction in days**. Inpatient costs (based on average inpatient unit daily costs) dropped from $315,541 to $105,887.

Six BAH-Simons participants had 13 contacts with the VA Emergency Department during the year prior to program admission, dropping to 11 contacts among six participants during the following year. This represents a **15% reduction in Emergency Department contacts**. Emergency Department costs (based on average ER unit encounter costs) rose slightly from $3,672 to $3,779. As such, **overall VA costs dropped by $209,761.**

Admissions and Days in Inpatient Psychiatric Hospitals

There were very few inpatient psychiatric hospitalizations among the BAH-Simons participants either before or after admission. The program did not select individuals on the basis of having a mental illness; however, as shown earlier, over 1/3 of the BAH-Simons participants had some indication of a mental illness. **Two BAH-Simons participants had a psychiatric hospitalization during the year prior to program entry (30 days total), and one person had four admissions (38 days total) during the following year.** This individual was one of the three who exited the program prior to the one year mark due to dangerous behavior. One hospitalization during the year prior to program entry (11 days) and one during the following year (14 days) are also accounted for within the Harborview data presented above.

King County Jail Bookings and Jail Days

Eleven BAH-Simons participants had at least one jail booking prior to entry into the program and 11 people had at least one booking during the following year. Seven of these participants had bookings during both periods. **The number of bookings did not show significant change, with 17 during the year prior to admission and 16 during the following admission**. Jail days rose from 124 total days to 260 total days, however one booking of 117 days accounted for nearly half of the jail days during the year following program admission.

Admissions to the Dutch Shisler Sobering Center

Fifteen BAH-Simons participants accrued 1,440 Sobering Center visits during the year prior to program entry. During the year following program entry, the number of **Sobering Center visits dropped 98%** to a total of 25 visits among nine people.

Cost Reductions

While we did not conduct a formal cost analysis for this evaluation, some cost information was available. First, we know that *participants reduced Harborview Medical Center charges by $364,273 and VA of Puget Sound costs by $209,761*.

We also know that 12 people met the shelter 'high utilizer' criteria of at least 200 shelter days during the three year period prior to admission. For these 12 individuals, if we use an average cost per night of $30 (range is estimated to be $10 – $59/night), we can estimate that their' shelter use cost $72,000 during the year prior to admission (12 X $30/night X 200 nights). Shelters were not used by these participants following admission to BAH-Simons, *reducing their shelter use cost to zero.*

We can also estimate the costs of Sobering Center contacts. For 2008, the Sobering Center contract was $1,249,785.50. Dividing this figure by the total number of contacts during 2008 (25,858) we can obtain a 'per contact' cost of $48.30. This figure is only an estimate as program costs remain largely fixed while the number of contacts can vary from year to year. BAH-Simons participants had 1,440 Sobering Center contacts during the year prior to admission, falling to 25 during the subsequent year – *a difference of 1,415 contacts or $68,345.*

As such, the combined Harborview, VA, shelter, and Sobering Center cost reductions during the first year following program admission are estimated to be $714,379 (average of $15,875 per participant). Also, certainly some of the other BAH-Simon participants used shelters prior to admission even if they did not use the 200+ nights that qualified them as high utilizers. Even without accounting for these savings, we can see that the estimated $480,580 per year (average of $10,680 per participant) in **program costs are offset by cost reductions in acute care and shelter use.** It should be noted that we cannot characterize reductions in acute care utilization as cost savings as the costs for running the hospitals and shelters have not actually been reduced – no units, staffing or shelters were eliminated. However, in the long-term, cost savings may be realized by consistent reductions in utilization that would prevent the need for more such facilities.

Cost reductions are, of course, only part of the story of Housing First programs. At least as important are the improvements in quality of life that accompany moving from long-term homelessness to stable housing. Some of these benefits are discussed below.

Income Support

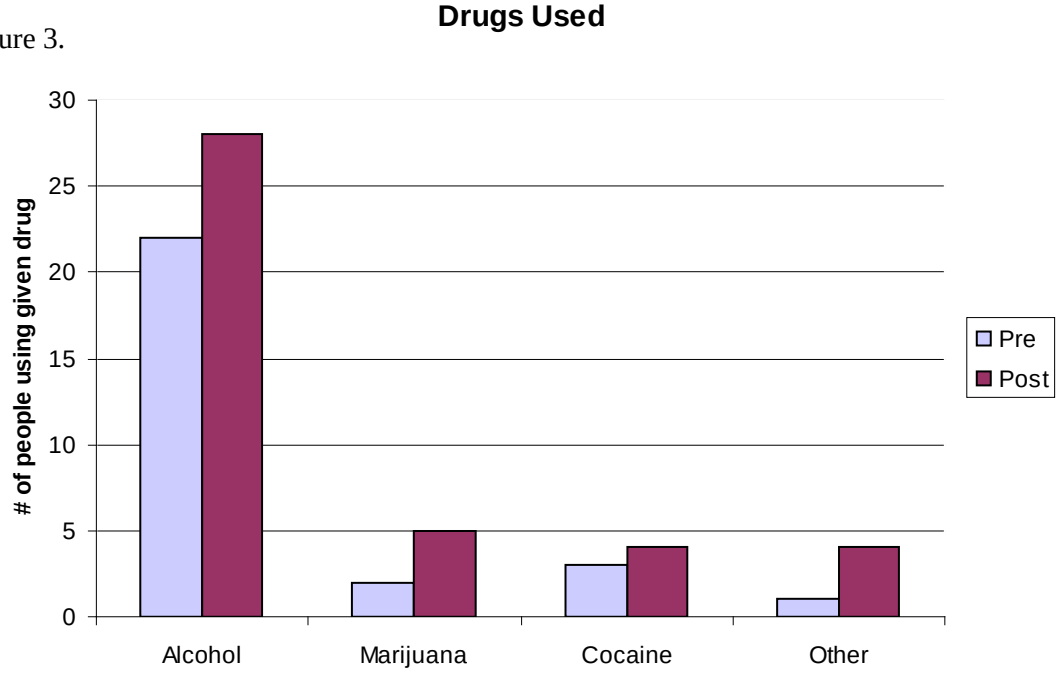
The average income across all BAH-Simons participants (including those who had 0 income) did not change significantly beginning with an average of $654.6 per month (SD=369.1) and remaining at an average of $674.2 per month (SD=361.4) after one year. Five people had no income at admission and four of these still had none after one year. One other person lost GAU benefits during the year.

Substance Use

Frequency of substance use was recorded with a tool that measured frequency of use in days and total time spent in activities necessary to obtain, use or recover from substance use. The tool is designed to be rated by case managers based on information gleaned from participants including observation of participants. However, in some instances, participants rated themselves and, due to staff turnover, ratings at program entry were generally made by someone different than the person rating at one year. These inconsistencies compromise the reliability of the data and as such, results should be viewed with caution. The data show that **23 BAH-Simons-participants were using alcohol or other drugs during the month of their program admission and 30 people were using one year later. However, 20 people also agreed with the statement "I am not using drugs as much"** when they reported responses to the six-month and 12-month survey (see Table 9). The types of drugs used during the baseline and one-year time points are shown below (see Figure 3).

We conducted further examination of the seven participants who, according to the data, were not using drugs or alcohol at admission but were using after one year. None had increased Harborview Emergency Department, Sobering Center or jail contacts. These findings give some support for the effectiveness of a harm reduction approach - rather than an abstinence approach. It is also possible that more people were actually using drugs and alcohol at the baseline point but were not forthcoming with this information or that the data are inaccurate.

Figure 3.



Engagement in Services

Engagement in services was rated on a 5-point scale as shown in the table below. Like the substance use rating, service engagement was intended to be rated by Housing Case Managers, however reliability was compromised by occasions in which participants rated themselves and by staff turnover. The table below shows that most individuals were quite engaged with services at the time of program admission, but that engagement tapered off over the subsequent year. It could be that as individuals stabilized in the program they felt they needed less from the Housing Case Managers and so pulled away from their services and support. Or it could be that a lower level of engagement is more typical of these individuals and it was only through exceptional efforts to engage them that Case Managers were able to get the individuals to agree to enter the program. Alternatively, it could be that Housing Case Managers expect relatively higher engagement levels with individuals over time such that if engagement levels remain the same, their perception of engagement declines. And, as noted earlier, these results should be viewed with caution due to inconsistencies in data collection methods

Table 8. Engagement in Services

Level of Engagement	At Entry	At 1 Year
Shares info; seeks guidance	17 (38%)	15 (33%)
Accepts some assistance	19 (42%)	12 (27%)
Engagement regarding basic needs only	3 (7%)	12 (27%)
Guarded	6 (13%)	5 (11%)
Very limited contact	0 (0%)	1 (2%)

Participant Self-Reported Program Impact

As described earlier, BAH-Simons participants were surveyed after six- and 12- months in the program. Participants were asked whether the list of life domains below had "improved":

Table 9. Participant Self-Reported Impacts on Life Domains

Life domains improved by BAH-Simons	6-month survey		12-month survey	
		N=42		N=41
Feeling "at home" where I live	32	76%	29	69%
Getting connected to services in the community	21	50%	19	45%
My physical health	22	52%	16	38%
Money concerns	21	50%	17	41%
My independence	20	48%	15	37%
My emotional health	14	33%	19	46%
My ability to get around	17	40%	12	29%
Work and/or job training opportunities	6	14%	2	5%
My ability to seek work	5	12%	4	2%

Participants were also asked, retrospectively, about the impacts of the program using the scale below. Items were derived from the Mental Health Statistics Improvement Project (MHSIP), a nationally-used survey instrument.

Figure 4. MHSIP Rating scale

Strongly agree 1	**Agree 2**	**I am neutral 3**	**Disagree 4**	**Strongly disagree 5**

Table 10. BAH-Simons Participant Self-reported Impacts on MHSIP Rating Scale

As a direct result of services....	6-month survey			12-month survey		
	N	% Agree/ Strongly Agree	Average rating	N	% Agree/ Strongly Agree	Average rating
My **housing** situation has improved	36	31 (86%)	1.5	38	33 (87%)	1.7
I am better able to **control my life**	36	32 (89%)	1.9	37	28 (76%)	2.0
I am better able to **deal with crisis**	33	23 (70%)	2.0	37	29 (78%)	2.0
I am not **using drugs** as much	29	20 (69%)	1.9	27	20 (74%)	2.0
I do more **productive** things during the day	33	23 (70%)	2.1	34	24 (71%)	2.1
I deal more effectively with **daily problems**	36	27 (75%)	2.0	37	24 (65%)	2.2
I am not **craving drugs** as much	30	21 (70%)	2.0	30	19 (63%)	2.2
I am getting along better with my **family**	27	18 (67%)	2.1	28	19 (68%)	2.2
My physical **health** is improved	36	22 (61%)	2.3	37	23 (62%)	2.3
My **symptoms** are not bothering me as much	29	16 (55%)	2.6	35	23 (66%)	2.3
I do better in **social** situations	32	19 (59%)	2.3	30	17 (57%)	2.5
I do better in **school and/or work**	15	6 (40%)	2.5	15	8 (53%)	2.1

The most frequently reported positive impact reported by BAH-Simons participants was an improved housing situation. Most participants also reported that all other areas targeted were improved including not using drugs, having more control over life and improvement in dealing with crises and daily problems. The overall average rating on the MHSIP items was the same (2.1) at both six- and 12- months however the pattern changed slightly with housing improvement most prominent within the first six months and improvement in work/school emerging only at the 12-month time point. The yes/no questions showed a similar pattern but also showed physical health improvements more prominent at six months, while improvements to emotional health emerged more strongly at 12 months.

S. arrived at Simons after reportedly being drunk for 12 years. When drunk, his home management skills suffer to the point that his unit became a health risk. S. has a closed head injury and a seizure disorder that requires daily medications, both of which contributed to confusion and incontinence when extremely intoxicated.

After about six months in the program and repeated failed inspections, he entered inpatient treatment. He experienced sobriety for the first time in over a decade. He engaged in formal intensive outpatient chemical dependency treatment and began working day labor at the stadium during games. He can quote you the entire history of the X baseball team and when the head coach of the local team comes to town, S. is invited into the locker room and hangs with the players. At the time of this report, S. was diagnosed with cancer and he began drinking again. He began failing inspections and not paying rent, so he agreed to a payeeship and weekly chore services. Relapse is a common part of recovery. Permanent housing is vital to individuals with severe substance use disorders so that a person can have an opportunity to try again.

SUMMARY

The BAH-Simons program successfully implemented a Housing First model with low barriers to housing access, rapidly housing 45 individuals directly from being homeless during the first six months of 2008. The model had no "readiness" criteria for individuals to access housing and no abstinence requirement. Residents were not required to participate in services to retain housing, however, Housing Case Managers were said to "knock often" at residents units to encourage engagement and participation.

Services for BAH-Simons integrated on-site mental health, chemical dependency and primary health care into a single, multidisciplinary team with a 1:23 client-to-case manager ratio. Funding from the Seattle Housing Authority, City of Seattle human services department and United Way of King County were braided to provide these services plus housing.

All BAH-Simons participants were older adults who had been frequent users of acute healthcare services, emergency shelters, or local jails. Two-thirds were veterans of the U.S. military. Participants had long histories of homelessness with length of homelessness ranging from four months to 42 years.

Process evaluation findings showed that **within one year, 40 to 45 BAH-Simons participants (89%) had contact with primary care** via the nurse on the BAH-Simons team. Within a year, 91% were also receiving some type of steady income support (e.g., social security, Veteran's Administration benefits) and 73% had health insurance.

Based on participant surveys, participants reported a wide range of positive aspects of the program, most frequently having their own place and the general care and help that they were provided. At the six-month survey, participants noted a **wide range of program impacts from improvement in housing, to not using drugs, to having more control over life and improvement in dealing with crises and daily problems**. At 12 months, participants also noted improvement in work and/or school. The only discernable theme among the areas reported for improvement was that participants would like the rules relaxed regarding guests.

BAH-Simons showed notable positive outcomes, particularly in housing retention and reduction in acute healthcare services. Specifically:

- ✓ Nearly all participants (93%) were retained in the BAH-Simons program for one year.
- ✓ Harborview inpatient admissions fell 76% and hospital days fell by 81% with hospitalization costs falling from $421,972 to $85,021
- ✓ Harborview Emergency Department contacts fell by 59% with a corresponding drop in costs from $287,190 to $114,776
- ✓ VA inpatient admissions for participants fell 65% and hospital days fell by 84%
- ✓ VA Emergency Department contacts fell by 59%
- ✓ Inpatient psychiatric hospitalizations rose slightly from two admissions (two people) to four admissions (one person)
- ✓ King County jail bookings showed no significant change, with 17 bookings for the BAH-Simons participants as a whole during the year prior to their admission and 16 during the subsequent year
- ✓ Sobering Center contacts fell from a startling 1,440 during the year prior to program entry to 25 during the subsequent year (98% reduction)

- ✓ For the first year of the program, total costs of $480,580 (average of $10,680 per person) were offset by reductions in acute care and shelter utilization of at least $714,379 (average of $15,875 per person), representing a savings of $233,799 (average of $5196 per person).

RECOMMENDATIONS

The positive findings from the BAH-Simons project -- particularly the remarkable reductions in use of high-cost acute care services -- suggest that a Housing First approach may be particularly worthwhile to stabilize individuals selected on the basis of intensive service needs and/or high service utilization.

While the BAH-Simons program results were quite strong, the findings should be viewed with caution as the evaluation capitalized on participant's previous high utilization that creates the high opportunity for seeing large reductions in utilization. Further, as noted in other Housing First reports, we do not know which program components (e.g., housing per se, engagement services, eviction prevention) have the strongest effects on results. Even with those caveats, the results of the BAH-Simons are strong enough to warrant continuation. Further examination might explore longer-term outcomes and factors that may contribute to outcome findings.

The evaluation data also suggest some points for potential program improvement. For example, the program may want to examine program rules regarding guests based on some negative comments by participants. The finding of apparently increased substance use among some participants residents suggests the need for increased attention to chemical dependency issues and continuation of on-site chemical dependency counseling and referral. However, substance use data was not collected in a consistent and reliable manner which could also have affected these results. Finally, while rates of inpatient psychiatric hospitalization and jail incarceration were relatively low, further investigation of each case in which these sentinel events occurred could be fruitful for a program improvement process.

Thus, the evaluation suggests the following:

- Continue successful efforts to house and reduce acute healthcare utilization
- Increase attention to chemical dependency issues and continue on-site counseling and referral
- Increase consistency and reliability of substance use ratings
- Further examine cases in which psychiatric hospitalization or incarceration occurred
- Improved oversight of data collection to ensure consistent measurements occur

Our findings suggest that these processes, coupled with selection of individuals most in need of housing plus intensive services, can lead to continued positive outcomes for BAH-Simons.

REFERENCES

Housing and Urban Development (2007, July). The applicability of Housing First models to homeless persons with serious mental illness.